

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-05-0667-01
Name of Patient:	
Name of URA/Payer:	
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician:	William Hicks, DC
(Treating or Requesting)	

February 24, 2005

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc:

William Hicks, DC
Texas Workers Compensation Commission

CLINICAL HISTORY

Documents Reviewed Included the Following:

1. Correspondence and reports from the provider
2. Treatment records for 2 dates of service
3. Pre-authorization for 15 sessions of Chronic Pain Management
4. Narrative from Bose Consulting, LLC
5. Carrier reviews and denials
6. Psychological reports
7. FCE

The claimant sustained a work-related injury in the course of her employment with ___ on ___. She was working in the capacity of a custodian when she slipped and fell, breaking her fall with her left hand and landing on her buttocks. She subsequently underwent passive and active therapy, MRI, EMG, NCS, ESI and 15 sessions of chronic pain management.

REQUESTED SERVICE(S)

Prospective medical necessity for an additional 15 sessions of chronic pain management program.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

While multiple narrative reports from multiple providers (one requesting 13 sessions of chronic pain management for a "Mr. Davis") were furnished, other than two single pages dated 10/20/04 and 11/03/04, the medical records submitted were void of any information detailing the patient's previous treatment or her daily response to the previously attempted 15 sessions of chronic pain management.

Moreover, no treatment records were furnished that would indicate what type of passive and active treatments had been previously attempted and whether or not the requested 8 psychological sessions had been attempted prior to the trial 15 sessions of chronic pain management. Since those treatments had within them the self-help strategies, coping mechanisms, exercises and modalities that are inherent in and central to the continued chronic pain management program, there is less than sufficient documentation to support the medical necessity of the proposed treatment.

The medical records submitted fail to document that chiropractic spinal adjustments were performed at any time. According to the AHCPR¹ guidelines, spinal manipulation was the only recommended treatment that could relieve symptoms, increase function and hasten recovery for adults suffering from acute low back pain. Based on those findings, it is both premature and medically unnecessary to continue a chronic pain management program until such time as a proper regimen ² of this recommended treatment has been attempted.

And finally, the medical records fail to substantiate that an additional 15 sessions of chronic pain management would fulfill statutory requirements ³ by relieving pain, promoting recovery or enhancing the employee's ability to return to employment.

¹ Bigos S., Bowyer O., Braen G., et al. Acute Low Back Problems in Adults. Clinical Practice Guideline No. 14. AHCPR Publication No. 95-0642. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services. December, 1994.

² Haas M, Group E, Kraemer DF. Dose-response for chiropractic care of chronic low back pain. Spine J. 2004 Sep-Oct;4(5):574-83. "There was a positive, clinically important effect of the number of chiropractic treatments for chronic low back pain on pain intensity and disability at 4 weeks. Relief was substantial for patients receiving care 3 to 4 times per week for 3 weeks."

³ Texas Labor Code 408.021

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 25TH day of February, 2005.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell